STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285054	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Banyan at Montclair	2525 South 135th Avenue Omaha, NE 68144

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18 Based on observations, record reviews and interviews: the facility staff failed to utilize handwashing and gloving techniques for 4 (Residents 5, 15, 28, and 41), failed to implement Enhanced Barrier Precautions (EBP) on 2 residents (Residents 5 and 15), failed to store equipment to prevent potential cross contamination for 1 resident (Resident 5), failed to implement isolation procedures for 1 (Resident 102) and fails to provide personal care in a manor to prevent potential infection for 1 (Resident 28). The total sample size was 53 and the facility census was 111. Findings are:Record review of the facility's Hand Hygiene policy with a revision date of 10/23/2025 revealed the following: 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. Record review of the facility's undated Hand Hygiene Table revealed the following: Before applying and after removing personal protective equipment (PPE), including gloves. Before preparing or handling medications. Before performing resident care procedures. A. Record review of Resident 28's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 3/2/2026 revealed the facility staff assessed the following about the resident: -Had a diagnosis of retention of urine. -Frequently incontinent of bowel. -Brief Interview of Mental Status (BIMS) was scored as 15/15. According to the MDS Manual a score of 15 indicated cognitively intact -required total assistance with toileting, shower/bath, putting on or taking off footwear, sit to stand, chair/bed transfers and tub transfers. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 5/11/2026 at 12:30 PM revealed Nursing Assistant (NA)-G completed hand hygiene, applied gown and gloves. NA-G removed Resident 28's brief, did not complete hand hygiene, did not change soiled gloves and obtained cleansing wipes. NA-G used one wipe to cleanse the furthest thigh, folded the wipe, cleansed the furthest thigh again and then discarded wipe. NA-G obtained a new wipe to cleanse the closets thigh, folded the wipe, cleansed closet thigh again and then discarded the wipe. NA-G did not remove the soiled gloves, did not complete hand hygiene, and obtained a new wipe to cleanse around the head of the penis, folded the wipe, cleansed the tubing away from the urinary meatus (a pathway leading into the body) and discarded the wipe. Resident 28 rolled to themself to the left side, NA-G obtained a new wipe and cleansed the anus wiping towards the front of the residents' body and discarded the wipe. NA-G obtained a new wipe, cleansed the anus wiping towards the legs, folded the wipe, wiped again and discarded the wipe. NA-G removed gloves, completed hand hygiene and put on new gloves. NA-G placed brief under Resident 28 and did not fasten the brief. NA-G removed gloves, did not complete hand hygiene and applied new gloves. NA-G fastened the brief and covered Resident 28 with a blanket. An interview on 5/11/2026 at 12:52 PM NA-G confirmed that hand hygiene was not completed between glove changes and should have been. An interview on 5/11/2026 at 12:52 PM NA-G confirmed that NA-G was wiping Resident 28 from back to front and should have been wiping from front to back. An interview on 05/12/2026 12:00 PM Licensed Practical Nurse (LPN)-B confirmed that staff should be completing perineal care by cleansing front to back. LPN-B confirmed that cleansing back to front introduces bacteria to the urinary tract. B. An observation during medication administration on 05/11/2026 at 1:00 PM Medication Aide (MA)-F gathered medications for Resident 41 and went into Resident 41s room. MA-F gave Resident 41 the medication in the medication cup. MA-F did not complete hand hygiene and put gloves on to administer muscle rub to Resident 41s bilateral knees. An interview on 5/11/2026 at 1:07 PM MA-F confirmed that hand hygiene was not completed prior to putting on gloves and should have been. C. A record review of Resident 5's Clinical Resident Profile (a sheet containing residents name, code status, primary diagnosis, admission date, personal contacts information and medical professionals contact information) revealed Resident 5 was admitted to the facility on [DATE]. A record review of Resident 5's Minimum Data set (MDS – a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents functional, medical, psychosocial and cognitive status), dated 2/11/2026, revealed Resident 5 had a Brief Interview for Mental Status (BIMS – a standardized assessment used in nursing homes to assess cognitive function, specifically memory and orientation) of 15, indicating Resident 5 was cognitively intact. A record review of Resident 5's Care plan (CP – a personalized, actionable document that outlines a patient's health needs, goals, and specific interventions to manage their care) revealed the following diagnoses: Chronic obstructive pulmonary disease (COPD- a progressive, treatable and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preventable lung disease characterized by chronic airflow obstruction, making it difficult to breathe), blindness in both eyes, personal history of malignant neoplasm of larynx (a previous diagnosis of laryngeal cancer that has been treated and is no longer present), unspecified severe protein-calorie malnutrition (a life-threatening condition resulting from inadequate intake of protein and calories, leading to severe weight loss, muscle wasting and immune system failure), Muscle wasting and atrophy (the loss of muscle tissue, resulting in smaller, weaker muscles caused by inactivity, aging, malnutrition, or nerve damage). A record review of Resident 5's Baseline Care Plan (BCP – a preliminary individualized care strategy developed in nursing homes within 48 hours of a resident's admission) revealed Resident 5 was admitted with a feeding tube in place. A record review of Resident 5's Order summary (a consolidated, authorized record of instructions from a licensed provider detailing a resident's care, treatment, medications, and services) revealed the following orders: -Order dated 09/10/2024 - Enteral Feed (a method of delivering nutrients directly into the gastrointestinal (GI) tract using a flexible tube) Order every shift Check g-tube (a soft, flexible, medically placed tube that delivers nutrition, fluids and medication directly into the stomach through a small opening in the abdomen) placement by introducing air and listening for air sounds on the stomach area as the air is introduced using a syringe. -Order dated 5/28/2025 - Enteral Feed: Cleanse enteral tube feeding site with Normal saline and apply dry dressing. Assess for abnormalities to insertion site. Report changes to PCP (primary care provider) every shift for monitoring. -Order dated 12/02/2025 - Enteral Feed Order two times a day related to unspecified severe protein-calorie malnutrition. Administer Jevity 1.5, (a high-protein, fiber-fortified and calorically dense liquid formula manufactured to provide complete, balanced nutrition for tube feeding) 300milliliters (ml – a unit of measurement for liquid) by gravity (a method that used gravity to deliver formula at a slow, controlled rate) through feeding tube. Prior to and post (after) feed, flush tube with 30ml of tap water for line patency (the state of the line or tube being open, unobstructed, and functioning properly) prior to and post feed. May substitute equivalent options of Isosource (liquid nutritional formula) 1.5 or osmolyte (liquid nutritional formula) 1.5. -Order dated 12/21/2025 - Enteral Feed Order four times a day related to unspecified severe protein calorie. Flush feeding tube with 110ml tap water four times daily by gravity. -Order dated 08/13/2025 - Enhanced Barrier Precautions due to percutaneous endoscopic gastrostomy (PEG) tube placement. Ensure appropriate PPE is used during resident care activities. every shift for infection prevention. An observation on 5/7/2026 at 9:40 AM of tube feeding provided by Licensed Practical Nurse (LPN) I revealed the following: LPN I entered Resident 5's room and placed 2 graduated cylinders and a 60ml syringe on the bedside table. LPN I placed a clean towel on Resident 5's abdomen and lap area. LPN I turned on the faucet and filled one cylinder with an unmeasured amount of water. LPN I then uncapped a box of Jevity 1.5 liquid formula feed and poured it into the second graduated cylinder. LPN I washed their hands and donned gloves but did not don a gown. LPN I approached Resident 5 and informed them of what they were about to do. LPN I verified placement of the g-tube by using the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	syringe to push 10cc of air through the g tube into the stomach while listening to the abdomen sounds with a stethoscope. LPN I placed the stethoscope around their neck and removed the syringe from the g-tube to remove the plunger part and reattach the syringe. LPN I poured 60ml of water into the syringe to flush the tube. The water did not flow in by gravity so LPN I pushed it through with the syringe plunger. LPN I removed the syringe and attached the tube section back to the g-tube after removing the plunger. LPN I poured the formula solution into the syringe. The feed did not flow through with gravity so LPN I added an unmeasured amount of water to thin it out. When it still did not flow through, LPN I attached the plunger and pushed the liquid formula through the tube into the stomach. LPN I removed the syringe, removed the plunger, reattached the syringe and poured an additional amount of formula into the syringe. This also did not respond to gravity so LPN I reattached the plunger and pushed the formula into the stomach. LPN I detached the plunger from the syringe and poured the last portion of the tube feed into the syringe and when it did not flow through, LPN I reattached the plunger and pushed it through. LPN I removed the plunger and poured 60ml of water into the g tube and this went through easily by gravity. LPN I detached the syringe and took the syringe and the cylinders into the bathroom and washed them. LPN I removed their gloves and washed their hands. LPN I removed the towel from Resident 5's lap and exited the room. LPN I informed Resident 5 they would return to clean around the g-tube site LPN I went to the treatment cart and gathered the cleaning supplies after reviewing the order. LPN I entered Resident 5's room after knocking and placed a bottle of wound cleanser, a package of 4 x 4 gauze and a clean towel on the bedside table. LPN I washed their hands and donned a gown and gloves. LPN I placed a towel on the residents lap. LPN I removed a small, uncounted amount of gauze pads from the package and sprayed them with the wound cleanser. LPN I wiped the gauze pad around the base of the g-tube side in a circular motion. LPN I removed their gloves and donned clean gloves without using hand sanitizer. LPN I placed a split sponge dressing (a precut absorbent pad designed to fit snugly around tubes) around the g-tube site. LPN I discarded their gloves and gown, picked up the towel, cleaner and package of gauze pads and exited the room without using hand sanitizer or washing their hands. An interview on 5/7/2026 at 10:05AM with LPN I confirmed the resident was on EBP precautions due to having a g-tube. LPN I confirmed they did not don a gown during the tube feeding and they should have. LPN I confirmed they did not use hand sanitizer or wash their hands between glove changes when providing g-tube site care and they should have. LPN I confirmed they did not wash their hands or use hand sanitizer when they exited the room after site care. LPN I confirmed Resident 5's order stated the tube feeding should have been delivered by gravity and confirmed they had pushed it through using the syringe plunger. LPN I confirmed they had exceeded the amount of water ordered for flush with tube feeding. A record review of the Facility Hand Hygiene policy dated 8/25/25 and reviewed 10/23/25 revealed the following: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. The policy stated: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. Hand hygiene is indicated and will be performed under the conditions listed in but not limited to, the attached hand hygiene table, which includes: After handling contaminated objects (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Before applying and after removing personal protective equipment (PPE) including gloves Before performing resident care procedures A record review of the Enhanced Barrier Precautions poster by Center for Disease Control revealed the following instructions: Providers and staff must wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting. Device care or use: Central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. A record review of a document titled Tube feeding: Process at Montclair: dated 12/2025 revealed the following: Washed hands and donned appropriate personal protective equipment. Adhered to infection control principles throughout the procedure. Flushed feeding tube with prescribed amount of fluid. Administered gravity feeding appropriately, as ordered. A record review of a document titled Enteral Feeding: Administration by syringe bolus dated 8/1/2016 and revised 11/16/2017 revealed the following: 9. Verify tube placement. 12. Flush tube with at least 50ml of water and instill by gravity. 13. slowly pour formula directly into syringe and instill using gravity. 14. Avoid letting the syringe empty completely. Increase or decrease the solution's flow rate by raising or lowering the syringe. Keep flow rate slow enough to spread feeding time over at least 20 minutes. 15. when all of formula is finished, flush with at least 50ml of water and instill by gravity. D. A record review of Resident 5's order summary revealed the following provider order dated 05/05/2026: Change nebulizer mask and tubing weekly; date and place in dated plastic bag. Date tubing. Place in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated bag when not in use. every night shift every Sat. For Infection Control Place in dated bag when not in use. An observation on 5/6/2026 at 1:45 PM of Resident 5's nebulizer mask (a medical device used to deliver liquid medication in the form of a fine mist directly into the lungs through the nose and mouth) and tubing placed directly on top of a table in Resident 5's room. An observation on 5/12/2026 at 8:10 AM of Resident 5's nebulizer mask and tubing resting on Resident 5's bedside table. An interview on 5/6/2026 at 1:45 PM with RN J confirmed the nebulizer mash should have been stored inside a dated plastic bag and not on top of a bedside table. An interview on 5/12/2026 at 8:10 AM with Medication Aide (MA) F confirmed the nebulizer mask and tubing should have been stored in a dated plastic bag and not lying on Resident 5's bedside table. E. An observation on 5/6/2026 at 1:45 PM of a urinal (a portable handheld container designed for collecting human urine) full of urine on Resident 5's bedside table beside a graduated plastic cylinder (plastic containers designed for measuring liquid) holding a 60ml syringe used to introduce water and a nutritional formula into Resident 5's stomach via a flexible tube. An interview on 5/6/2026 at 1:45 PM with Registered Nurse (RN) J confirmed having the urinal full of urine beside the graduated cylinder and syringe used to deliver the liquid formula constituted an infection control issue. F. A record review of the facility's undated Enhanced Barrier Precautions (EBP) sign revealed providers and staff must wear gloves and a gown for high-contact resident care activities such as dressing, transferring, changing linens, providing hygiene (cleaning), changing briefs of assisting with toileting, and device care. A record review of Resident 15's Order Summary Report dated 05/07/2026 revealed the resident had orders to cleanse the right heel with wound cleanser, apply honey hydrogel sheet (a wound dressing) to the wound bed, and cover with a border dressing. It did not reveal orders for pressure wound prevention measures. An observation on 05/11/2026 at 7:56 AM revealed that Nursing Assistant (NA)-A was already in the room with a gown and gloves on and had changed the resident's brief. Licensed Practical Nurse (LPN)-K was in the room to observe MA-A and there was an EBP to the left of the door as you enter the room. NA-A removed NA-A's gloves and applied a new pair without performing hand hygiene between glove changes. NA-A drained the resident's colostomy (an opening on the abdominal wall that allowed the colon to divert waste into an external bag) bag. The colostomy was leaking, so NA-A called for the nurse to replace it. The colostomy had leaked onto the resident's shirt, so NA-A (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removed gloves, got the resident shirt, gloved, without hand hygiene, and wiped the colostomy site again and removed NA-A's gloves. The nurse entered and started to change the colostomy and NA-A lifted the resident's hands out of the way without gloves on, then applied gloves without performing hand hygiene. The nurse completed the colostomy change, and NA-F rolled the resident to the left and to the right as NA-F removed the reusable chux (absorbent pad), pulled the resident's pants over the resident's brief, removed NA-A's gloves, re-gloved without hand hygiene, assisted the resident to a seated position on the side of the bed, and removed gloves. NA-A done hand hygiene, re-gloved, finished dressing the resident, transferred the resident to the wheelchair, put contaminated clothing and linens in a trash bag and removed gloves. NA-A then brushed and combed the resident's hair, touched around NA-A's mouth, and applied water to Resident 15's brown all without hand hygiene or gloves on. NA-A gloved without performing hand hygiene, applied lotion to the resident's face, removed gloves and gown, and took the resident to the dining room after washing NA-A's hands. In an interview on 05/11/2026 at 9:00 AM, LPN-K confirmed NA-A changed gloves without performing hand hygiene in between and did not have gloves on when working with the resident and should have. G. A record review of Resident 15's Progress Notes dated 04/29/2026 revealed the nurse assessed the area on resident's right heel and it was open again. The nurse cleaned with wound cleanser, applied betadine, and secured with bordered dressing. An observation on 05/06/2026 at 1:00 PM did not reveal an EBP sign on Resident 15's door or in the resident's room. An observation on 05/07/2026 at 11:08 AM, 1:40 PM, and 2:26 PM did not reveal an EBP sign on Resident 15's door or in the resident's room. An observation on 05/11/2026 at 6:52 AM revealed there was an EBP sign posted to the left of the entry door to Resident 15's room. In an interview on 05/11/2026 at 10:15 AM, the facility's Infection Preventionist (IP)-E confirmed Resident 15's room did not have an EBP sign posted until IP-E was informed of the resident having a new wound and it was not posted until after 05/07/2026. H. A record review of the facility's undated Neutropenic Precautions sign revealed everyone must: clean hands before entering the room and when leaving the room, and Face mask required! An observation on 05/06/2026 at 8:14 AM – 8:25 AM revealed there was a Neutropenic Precautions sign to the left of the door to Resident 102's room. At 8:19 AM the facility's Maintenance Director (MD) entered Resident 102's room, exited the room and spoke to staff, and re-entered the room to check the water temperature without a face mask on or performing hand hygiene. In an interview on 05/12/2026 at 11:20 AM, the Infection Preventionist (IP)-E confirmed the MD should not have entered Resident 102's room without a face mask and doing hand hygiene.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.5(G)Based on record review and interview the facility failed to ensure that a psychotropic medication had an adequate indication for use for Resident 5, and side effect monitoring was in place for residents 10 and 105 of 6 sampled residents. The facility identified a census of 111. Findings are: A. A record review of the facility's Medication Regimen Review policy, with an implementation date of 4/1/2023 and a revised date of 1/8/2026 revealed the following: Policy: The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. Policy Explanation and Compliance Guidelines: 1. Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes: Review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. 5. The pharmacist shall communicate any irregularities to the facility in the following ways: Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs. Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing. 7. Timelines and responsibilities for Medication Regimen Review: The pharmacist shall communicate any recommendations and identified irregularities via written communication within 10 working days of the review. Facility staff shall act upon all communications according to procedures for addressing medication regimen review irregularities. B. A record review of Resident 5's Clinical Resident Profile (a sheet containing residents name, code status, primary diagnosis, admission date, personal contacts information and medical professionals contact information) revealed Resident 5 was admitted to the facility on [DATE]. A record review of Resident 5's Minimum Data set ((MDS – a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functional, medical, psychosocial and cognitive status), dated 2/11/2026, revealed Resident 5 had a Brief Interview for Mental Status (BIMS – a standardized assessment used in nursing homes to assess cognitive function, specifically memory and orientation) of 15, indicating Resident 15 was cognitively intact. A record review of Resident 5's Care Plan (CP – a personalized, actionable document that outlines a patient's health needs, goals and specific interventions to manage their care) revealed they had the following diagnosis: Insomnia (a common sleep disorder characterized by persistent difficulty falling asleep, staying asleep or waking too early, despite having the opportunity to sleep). A record review of Resident 5's physicians order summary (a consolidated, authorized record of instructions from a licensed provider detailing a resident's care, treatment, medications and services) dated 5/11/2026, revealed Resident 5 had an order, dated 02/10/2026, for Seroquel (a prescription antipsychotic medication used to treat schizophrenia, bipolar disorder and major depressive disorder) 50mg tablet at bedtime related to Insomnia. A record review of Resident 5's Medication Administration Record (MAR) for April 2026 revealed Resident 5 received Seroquel 50mg every night except April 5th, 2026, and April 26th, 2026, and every night between May 1st, 2026, and May 10th, 2026. A record review of a Consultant Recommendation to Physician dated 2/18/2026 from the consultant pharmacist to a physician revealed Resident 5 lacked an allowable diagnosis for the use of Seroquel and requested a different diagnosis from the physician to support the continued use of the medication. A record review of Resident 5's order summary dated May 11, 2026, revealed there was no new diagnosis attached to the order for Seroquel 50mg tablet. An interview on 05/12/2026 at 11:30 AM with the Director of Nursing (DON) confirmed if a response is not received within 2 weeks of the recommendation being sent to the physician the Assistant Director of Nursing (ADON) or the DON would send a second request by fax to the provider. The DON confirmed that this process would continue until a response was received from the provider. The DON confirmed they were unable to provide documentation to show the request for an allowable diagnosis had been faxed to Resident 5's provider. C. Record review of Resident 105's admission Record dated May 11, 2026 revealed an admission date to the facility on [DATE] with diagnosis of Alzheimer's disease, dementia with anxiety and psychosis, and depression. Record review of Resident 105's May 2026 MAR revealed that Resident 105 had an order for Risperidone (a psychotropic medication) 0.5mg one tablet twice daily. Record review of Resident 105's EHR revealed there was no side effect monitoring for psychotropic medications for Resident 105. In an interview with the Director of Nursing (DON) on 5/12/26 at 8:25 A.M. it was confirmed that there was no side effect monitoring for residents 10 and 105 and should have been.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to investigate and report a fall with significant injury within the required time frame for 1(Resident 63) of 1. The facility reported a census of 111. Findings are: A record review of Resident 63's Clinical Resident Profile (a sheet containing residents name, code status, primary diagnosis, admission date, personal contacts information and medical professionals contact information) revealed Resident 63 was admitted to the facility on [DATE].A record review of Resident 63's Minimum data set (MDS - a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents functional, medical, psychosocial and cognitive status) dated 4/5/2026 revealed Resident 63 had a Brief Interview for Mental Status (BIMS - a standardized assessment used in nursing homes to assess cognitive function, specifically memory and orientation) of 5 indicating Resident 63 was severely cognitively impaired.A record review of Resident 63's care plan (CP - a personalized, actionable document that outlines a patient's health needs, goals and specific interventions to manage their care) revealed Resident 63 had the following diagnoses: Vascular dementia - a decline in thinking, memory and behavior caused by conditions that block or reduce blood flow to the brain, depriving it of oxygen and nutrition, essential hypertension - high blood pressure with no single identifiable medical cause, Chronic kidney disease, stage 3 - moderate kidney damage, where kidneys do not filter waste and fluids as efficiently as they should, Pain, Diabetes type 2 - a chronic condition where the body cannot properly use or make enough insulin, leading to high blood sugar levels, peripheral vascular disease - a slow progressive circulation disorder involving narrowing, blockage or spasms in blood vessels outside the heart and brain, obstructive sleep apnea - a serious sleep disorder where breathing repeatedly stops and starts because throat muscles relax and block the airway during sleep, spinal stenosis - chronic narrowing of the spaces within the spinal canal causing pain, major depressive disorder - a serious mental health condition characterized by persistent severe low mood, sadness or a loss of interest in activities lasting at least 2 weeks, morbid obesity - a body mass index of 40 or higher or 35 or higher accompanied by a serious, obesity related health condition. Further review of Resident 63's CP revealed Resident 63 was considered to be at risk for falls related to Type 2 diabetes, Hypertension, spinal stenosis, weakness, and decreased mobility.A record review of Resident 63's progress note by RN L revealed Resident 63 had a fall on 5/2/2026 resulting in a laceration (a torn or jagged wound caused by the tearing or stretching of soft body tissues, often resulting from blunt trauma) to their left eyebrow requiring sutures (medical devices used to hold body tissues together and approximate (bring the edges together) tissues). The progress note revealed Resident 63 was found on the floor and did not reveal how the laceration occurred. Resident 63 was transferred to the emergency department where they received sutures in the laceration. An interview on 5/12/26 at 1:45PM with Director of Nursing (DON) confirmed the facility did not report the residents fall with significant on 5/2/2026 and did not perform an investigation.

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	285054	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Banyan at Montclair	2525 South 135th Avenue Omaha, NE 68144

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1) Based on observation, interview, and record review, the facility failed to implement interventions to prevent the potential for pressure injuries on 1 (Resident 15) of 5 sampled residents. The facility census was 111. Findings are:A record review of the facility's Use of Support Surfaces policy with a date reviewed/revised of 2/26 revealed a support surface was a specialized mattress, overlay, or chair cushion to manage pressure, shear, microclimate, or friction on tissue. Support surfaces would be utilized in accordance with manufacturer's recommendations. A record review of the facility's Turning and Repositioning policy with a date reviewed/revised date of 2/2026 revealed all residents at risk of or had existing pressure injuries would be turned and repositioned. The frequency of turning and repositioning would be documented in the resident's care plan. If the resident had a pressure redistribution support surface in use, turning and reposition was still required but may be less frequent. If the resident was in bed, the staff was to ensure heels were floated off the surface of the bed. If the resident was in a chair, staff was to ensure feet were properly supported on the footrests. A record review of the undated SpanAmerica's Geo-Mattress Pro Pressure Redistribution Foam Mattress information sheet revealed the mattress had a exclusive heel slope that had a subtle taper to redistribute load to pressure tolerant lower legs and reduce heel pressure by 27 percent (%) compared to a flat mattress. Patient indications were general patient population, with moderate to high risk for skin breakdown, had decreased mobility, and was repositioned frequently by self or a caregiver. A record review of Resident 15's Clinical Census dated 05/07/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 15's Medical Diagnosis dated 05/07/2026 revealed the resident had diagnoses of Unspecified Dementia, Stage III Chronic Kidney Disease, Polymyalgia Rheumatica (inflammatory disorder causing severe muscle pain and stiffness), and Osteoarthritis Of The Left Knee (cartilage breakdown resulting in pain, stiffness, and reduced mobility). A record review of Resident 15's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 03/10/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 00 which indicated the resident was severely cognitively impaired (confused). The resident required setup/clean-up assistance with eating, partial/moderate assistance with oral hygiene (cleaning), substantial/maximal assistance with footwear, dressing, and personal hygiene, and was dependent on staff for toileting hygiene and bathing. The resident required partial/moderate assistance with rolling left and right, and required substantial/maximal assistance with all other bed mobility and transfer needs. The resident was at risk of developing a pressure ulcer/injury and the resident did not have a pressure ulcer (wound) at the time of the assessment. A record review of Resident 15's Wound Assessment Report dated 04/30/2026 by the Nurse Practitioner revealed the resident had a new stage 3 pressure ulcer/injury to the right heel that measured 1.10 centimeters (cm) in length, .60 cm in width, and .10 cm in depth, and light exudate (wound drainage). The wound was acquired 04/28/2026 in house (at the facility). A record review of Resident 15's Progress Notes dated 03/31/2026 - 04/29/2026 revealed: - On 03/31/2026 the resident's provider seen the resident and no wounds were documented. - On 04/02/2026 the facility identified a 1.8 cm long by 1.2 cm wide area to the resident's right heel and orders were obtained for betadine 2 times per day. It appeared the skin alteration was possibly due to improper footwear (Crocs, with no socks) and the resident's family was to bring a different pair of shoes. - On 04/29/2026 the nurse assessed the area on resident's right heel was open again. The nurse cleaned with wound cleanser, applied betadine, and secured with bordered dressing. A record review of Resident 15's Progress Notes dated 04/30/2026 revealed the Nurse Practitioner (NP) evaluated the wound and changed the orders. The NP documented that previously the wound care nurse thought the right heel wound was healed out, but discovered the wound was reopened. The resident's wound was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initially caused by Crocs and friction on the resident's heel and the resident had new shoes. The NP recommended avoiding pressure on any boney prominence (projecting outward) by adhering to turning protocols and floating heels (ensuring heels do not touch the mattress). The resident now had proper fitting footwear, Sketchers tennis shoes that properly fit and the Crocs were no longer in the room. A record review of Resident 15's Order Summary Report dated 05/07/2026 revealed orders to cleanse the right heel with wound cleanser, apply honey hydrogel sheet (a wound dressing) to the wound bed, and cover with a border dressing. It did not reveal orders for pressure wound prevention measures. A record review of the facility's Wound Tracker 2026 dated 04/10/2026 revealed Resident 15 was listed dated 04/02/2026 with a right superior (located above) heel abrasion and treatment was betadine twice a day. A record review of the facility's Wound Tracker 2026 dated 04/22/2026 revealed Resident 15 was listed dated 04/02/2026 with a right superior heel abrasion, treatment was betadine twice a day, and it was marked healed. A record review of Resident 15's Clinical Physician Orders dated 05/11/2026 that was filtered to show orders that were completed or discontinued did not reveal any orders for pressure wound prevention, and did not reveal wound care or betadine to the right heel until 04/30/2026. A record review of Resident 15's Medication Administration Record and Treatment Administration Record (MAR & TAR) dated April 2026 did not reveal any orders for pressure wound prevention and did not reveal wound care or betadine to the right heel until 04/30/2026. A record review of Resident 15's MAR & TAR dated May 2026 did not reveal any orders for pressure wound prevention. A record review of Resident 15's Care Plan Report with an admission date of 08/26/2025 revealed a Focus area of Pressure Ulcer Risk and the resident had the potential to develop a pressure ulcer and had an open area to the right heel. The only intervention was weekly skin checks to monitor for redness, pressure sores, open areas, and skin integrity (overall health). A record review of Resident 15's Bed Mobility: Self Performance task dated 04/12/2026 - 05/11/2026 revealed the resident was extensive assistance to total dependence on staff for bed mobility all but 2 times in those 30 days and the resident was only assisted once or twice per day. An observation on 05/07/2026 at 1:40 PM revealed Licensed Practical Nurse (LPN)-C who was the wound care nurse completed wound care on Resident 15's right heel, put the sock on the resident, discarded all wound care supplies, removed LPN-C's gown and gloves, and put the resident's foot back flat on bed. The Nursing Assistant (NA) came into the room and took trash to hopper and asked the resident if they wanted to get in the wheelchair and the resident wanted to stay in bed. LPN-C and the NA left the room and the resident's heels were flat on the surface of the bed. An observation on 05/07/2026 at 2:26 PM revealed Resident 15 was in bed, feet flat on the mattress, knees bent up, and no pillow underneath the resident's lower legs. An observation on 05/11/2026 at 6:52 AM revealed Resident 15 was sleeping in bed and the resident's heels were flat on the mattress. An observation on 05/11/2026 at 2:27 PM with LPN-C, the wound care nurse, revealed the mattress on Resident 15's bed had tags that revealed it was a Span-America 54668 mattress that was a Geo-Mattress Pro that did have a heel slope, but the tag that said foot end was at the head of the bed and the heel slope was on the upper body portion of the bed. In an interview on 05/11/2026 at 2:00 PM, LPN-D, a wound care nurse, confirmed LPN-D was monitoring the wound after it was identified on 04/02/2026, but another nurse was doing the wound care. At the time, the resident had wandering (roaming) behaviors and Prevalon boots (padded heel protectors) were not a safe option for the resident. LPN-D confirmed LPN-D told the staff to float the resident's heels, but an order was not put in the system, and it was not on the care plan. LPN-D confirmed turning and repositioning should have been completed per standards of practice and the facility's protocol. In an interview on 05/11/2026 at 1:30 PM, LPN-C, the wound care nurse, revealed the resident had a wound on the right heel that was identified on 04/02/2026, was healed on 04/22/2026, and reopened on 04/28/2026. They think it was from Resident 15's shoes rubbing on the resident's heel, so they decided to have the resident wear nonskid socks with therapy. LPN-C confirmed the only intervention put in place between when the right heel wound was identified on 04/02/2026 and finding it reopened on 04/30/2026 was monitoring the right heel, changing the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's shoes, nothing for when the resident was in bed. LPN-C confirmed the facility used pressure redistribution mattresses on all beds to assist on pressure reduction to the heels. In an interview on 05/11/2026 at 2:27 PM, LPN-C confirmed Resident 15 had a Span-America 54668 Pressure Redistribution Foam Mattress on the bed, but the tag on the mattress that said Foot End was by the bed's headboard and therefore the heel slope was on the wrong end of the bed. In an interview on 05/11/2026 at 3:40 PM, the facility's Maintenance Director (MD) confirmed the MD moved the resident to room [ROOM NUMBER] and put the mattress on the bed and did not pay attention to there being a specific direction that mattress needed to go. The MD confirmed the maintenance staff and NAs apply the mattresses to the beds. The MD confirmed the staff had not been educated on that mattress. In an interview on 05/12/2026 at 10:05 AM, the facility's Administrator confirmed the staff had not had a competency (education) on the placement of the SpanAmerica's Geo-Mattress Pro.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I)(1)(i)Based on record review and interview, the facility failed to implement a new fall intervention for Resident 63 following a fall on 05/02/2026. The facility reported a census of 111. Findings are:A record review of the facility Accidents and Supervision policy dated 4/1/24 and reviewed on 2/2026 revealed the following:Implementation of interventions - using specific interventions to try to reduce a resident's risk from hazards in the environment. The process includes:Communicating the interventions to all relevant staffProviding training as neededDocumenting the interventions (plans of action developed through the QAA Committee or care plans for the individual resident. A record review of Resident 63's Clinical Resident Profile (a sheet containing residents name, code status, primary diagnosis, admission date, personal contacts information and medical professionals contact information) revealed Resident 63 was admitted to the facility on [DATE].A record review of Resident 63's Minimum data set (MDS - a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents functional, medical, psychosocial and cognitive status) dated 4/5/2026 revealed Resident 63 had a Brief Interview for Mental Status (BIMS - a standardized assessment used in nursing homes to assess cognitive function, specifically memory and orientation) of 5 indicating Resident 63 was severely cognitively intact.A record review of Resident 63's Care Plan (CP - a personalized, actionable document that outlines a patient's health needs, goals and specific interventions to manage their care) revealed Resident 63 had the following diagnoses: Vascular dementia - a decline in thinking, memory and behavior caused by conditions that block or reduce blood flow to the brain, depriving it of oxygen and nutrition, essential hypertension - high blood pressure with no single identifiable medical cause, Chronic kidney disease, stage 3 - moderate kidney damage, where kidneys do not filter waste and fluids as efficiently as they should, Pain, Diabetes type 2 - a chronic condition where the body cannot properly use or make enough insulin, leading to high blood sugar levels, peripheral vascular disease - a slow progressive circulation disorder involving narrowing, blockage or spasms in blood vessels outside the heart and brain, obstructive sleep apnea - a serious sleep disorder where breathing repeatedly stops and starts because throat muscles relax and block the airway during sleep, spinal stenosis - chronic narrowing of the spaces within the spinal canal causing pain, major depressive disorder - a serious mental health condition characterized by persistent severe low mood, sadness or a loss of interest in activities lasting at least 2 weeks, morbid obesity - a body mass index of 40 or higher or 35 or higher accompanied by a serious, obesity related health condition.A record review of Resident 63's CP revealed Resident was considered to be at risk for falls related to Type 2 diabetes, Hypertension, spinal stenosis, weakness, and decreased mobility.A record review of Resident 63's progress notes revealed Resident 63 had a fall on 5/2/2026 resulting in a laceration to their left eyebrow requiring sutures.A record review of Resident 63's CP did not reveal any new fall interventions for the fall on 5/2/2026.An interview on 5/12/2026 at 7:55 AM with Licensed Practical Nurse (LPN) I revealed the following steps nursing is required to take after a resident has fallen.Assess the resident.Notify the physician, Director of Nursing (DON), and family members.Begin neurochecks (serial, abbreviated neurological examinations performed by healthcare providers to quickly monitor for changes in a patients neurological status) if the fall is not witnessed.Complete a fall assessment and risk management paperwork which is to include a new fall intervention (an intentional action, step or interference taken to alter the course of a situation, improve a condition or prevent a negative outcome).An interview on 5/12/2026 at 7:55 AM with LPN I confirmed they were unable to find a new intervention related to the fall on 5/2/2026 on Resident 63's care plan.An interview on 5/12/2026 at 7:56 AM with Medication Aide (MA) F confirmed they were unable to find a new intervention related to Resident 63's fall on 5/2/2025 on the residents care (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan.An interview on 5/12/2026 at 9:17 AM with LPN B confirmed they were unable to find a new intervention related to Resident 63's fall on 5/2/2025 on the residents care plan.An interview on 5/12/26 at 12:15pm with the MDS Director confirmed a new intervention had not been placed in the residents care plan for the fall on 5/2/26.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Licensure Reference Number 175 NAC 12-006.9(H)(iv) Based on record reviews and interviews the facility failed to ensure that a bowel protocol was followed for 1 resident (Resident 2) of 5 sampled residents. The facility identified a census at 111. Findings are:A.Record review of the facility's policy Constipation Prevention dated 8/1/2023 revealed the following:PRN Laxative will be offered during the 3rd day without a BM. The PRN Laxative will be offered and preferably administered by 2:00pm. Example: no BM on the 1st and 2nd, PRN laxative too be offered on the 3rd.A suppository will be offered the AM of the 4th day without a BM. Example: no BM on the 1st, 2nd and 3rd, a suppository will be offered the AM of the 4th.If a resident does not have a BM after PRN laxative and a suppository is provided, an assessment of the abdomen, bowel sounds, pain and appetite will be completed. The primary physician will be notified.When a resident is using PRN laxative/suppository on a regular basis, update the primary physician and request a routine stool softener/laxative. B.Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 3/9/2026 revealed the facility staff assessed the following about the resident:-Had a diagnosis of non-Alzheimer dementia, Hemiplegia or hemiparesis, seizure disorder or epilepsy-Always incontinent of bowel-Brief Interview of Mental Status (BIMS) was scored as 12/15. According to the MDS Manual a score of 12 indicated moderate cognitive impairment. -Required total assistance with toileting, shower/bathing and transfers Record review of Resident 2's Bowel Movement (BM) tasks dated 5/12/2026 revealed Resident 2 had not had a documented BM since 5/1/2026, eleven days. An interview on 5/12/2026 at 12:50 PM Assistant Director of Nursing (ADON)-H confirmed that a BM had not been documented since 5/1/2026. ADON-H confirmed that it had been eleven days without a BM documented for Resident 2. An interview on 05/12/2026 2:57 PM ADON-H confirmed that Pro Re Nata (PRN) (as needed) medications were not provided to Resident 2. ADON-H confirmed that there was no assessment completed on Resident 2. ADON-H confirmed that there was not any progress notes completed regarding Resident 2 having a BM or that an assessment was completed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12(A)(4)Based on record review and interview, the facility failed to ensure a medication irregularity was reported to the attending physician and failed to ensure the report was acted on for 1 (Resident 5) of 5 sampled residents.The facility reported a census of 111. Findings are: A record review of the facility's Medication Regimen Review policy, with an implementation date of 4/1/2023 and a revised date of 1/8/2026 revealed the following.Policy:The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart.Policy Explanation and Compliance Guidelines:1. Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes:Review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities.5. The pharmacist shall communicate any irregularities to the facility in the following ways:Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs.Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing.7. Timelines and responsibilities for Medication Regimen Review:The pharmacist shall communicate any recommendations and identified irregularities via written communication within 10 working days of the review.Facility staff shall act upon all communications according to procedures for addressing medication regimen review irregularities. A record review of Resident 5's Clinical Resident Profile (a sheet containing residents name, code status, primary diagnosis, admission date, personal contacts information and medical professionals contact information) revealed Resident 5 was admitted to the facility on [DATE]. A record review of Resident 5's Minimum Data set ((MDS - a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents functional, medical, psychosocial and cognitive status), dated 2/11/2026, revealed Resident 5 had a Brief Interview for Mental Status (BIMS - a standardized assessment used in nursing homes to assess cognitive function, specifically memory and orientation) of 15, indicating Resident 15 was cognitively intact.A record review of Resident 5's Care Plan (CP - a personalized, actionable document that outlines a patient's health needs, goals and specific interventions to manage their care) revealed they had the following diagnosis: Insomnia (a common sleep disorder characterized by persistent difficulty falling asleep, staying asleep or waking too early, despite having the opportunity to sleep).A record review of Resident 5's physicians order summary (a consolidated, authorized record of instructions from a licensed provider detailing a resident's care, treatment, medications and services) dated 5/11/2026, revealed Resident 5 had an order, dated 02/10/2026, for Seroquel (a prescription antipsychotic medication used to treat schizophrenia, bipolar disorder and major depressive disorder) 50mg tablet at bedtime related to Insomnia.A record review of a Consultant Recommendation to Physician dated 2/18/2026 from the consultant pharmacist to a physician revealed Resident 5 lacked an allowable diagnosis for the use of Seroquel and requested a different diagnosis from the physician to support the continued use of the medication.A record review of Resident 5's order summary dated May 11, 2026, revealed there was no new diagnosis attached to the order for Seroquel 50mg tablet.An interview on 05/12/2026 at 11:30AM with the Director of Nursing (DON) confirmed the following procedure: a Consultant Recommendation to Physician is sent by the consultant pharmacist to the physician, the DON, and the Medical Director of the facility. The DON confirmed if a response is not received within 2 weeks of the recommendation being sent to the physician the Assistant Director of Nursing (ADON) or the DON would send a second request by fax to the provider. The DON confirmed that this process would continue until a response was received from the provider. The DON confirmed (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they were unable to provide documentation to show the request for an allowable diagnosis had been faxed to Resident 5's provider.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D) Based on interview and record review, the facility failed to ensure that 2 (Resident 5 and 15) of 5 sampled residents were free of significant medication errors. The facility census was 111. Findings are:A record review of the facility's Medication Errors policy with a date last reviewed/revised of 2/2026 revealed a significant medication error meant one which causes the resident discomfort or jeopardizes the resident's health and safety. The facility should ensure medications were administered according to physician's orders. A record review of the facility's Medication Administration policy with a date reviewed/revised of 02/2026 revealed medications would be administered by staff who are legally authorized to do so, as ordered by the physician, and in accordance with professional standards of practice. A. A record review of Resident 15's Clinical Census dated 05/07/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 15's Medical Diagnosis dated 05/07/2026 revealed the resident had diagnoses of Unspecified Dementia, Stage III Chronic Kidney Disease, Infrarenal Abdominal Aortic Aneurism (a dangerous bulge in the main blood vessel), Cardiac Murmur (unusual sound during a heartbeat), and Essential (Primary) Hypertension (high blood pressure). A record review of Resident 15's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 03/10/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 00 which indicated the resident was severely cognitively impaired (confused). The resident required setup/clean-up assistance with eating, partial/moderate assistance with oral hygiene (cleaning), substantial/maximal assistance with footwear, dressing, and personal hygiene, and was dependent on staff for toileting hygiene and bathing. The resident required partial/moderate assistance with rolling left and right, and required substantial/maximal assistance with all other bed mobility and transfer needs. A record review of Resident 15's Care Plan Report with an admission date of 08/26/2025 revealed a focus area of the resident had hypertension and an intervention of medication as ordered. A record review of Resident 15's Order Summary Report dated 05/07/2026 revealed the resident had a provider's order for Hydralazine Hydrochloride (HCL) oral tablet 25 milligram (MG). Give 1 tablet by mouth three times per day. HOLD FOR SPB (systolic blood pressure) LESS THAN (<) 115 millimeters of hemoglobin (mmHg). A record review of Resident 15's Medication Administration Record and Treatment Administration Record (MAR & TAR) dated February 2026 with Licensed Practical Nurse (LPN)-B revealed the resident's Hydralazine HCL was to be held if SBP < 115 mmHg and was administered with an SBP of < 115 mmHg on: - the 02/15/2026 2:00 PM dose the SBP was 113 mmHg - the 02/15/2026 PM dose the SBP was 109 mmHg (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285054	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Banyan at Montclair	2525 South 135th Avenue Omaha, NE 68144

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the 02/26/2026 AM dose the SBP was 114 mmHg - the 02/27/2026 AM dose the SBP was 112 mmHg A record review of Resident 15's MAR & TAR dated April 2026 with LPN-B revealed the resident's Hydralazine HCL was to be held if SBP was < 115 mmHg and it was administered with an SBP of < 115 on: - the 04/11/2026 AM dose the SBP was 113 mmHg - the 04/13/2026 AM dose the SBP was 104 mmHg - the 04/13/2026 2:00 PM dose the SBP was 112 mmHg A record review of Resident 15's MAR & TAR dated May 2026 with LPN_B revealed the resident's Hydralazine HCL was to be held if SBP < 115 mmHg and was administered with an SBP of less than 115 on: - the 05/07/2026 PM dose the SBP was 112 mmHg - the 05/08/2026 PM dose the SBP was 102 mmHg In an interview on 05/12/2026 at 10:13 AM, LPN-B confirmed that LPN-B reviewed the above values and confirmed Resident 15's Hydralazine HCL was administered on the above dates with and SBP of < 115 mmHg and should not have been. LPN-B confirmed that would be a medication error. A record review of Resident 5's Clinical Resident Profile (a sheet containing residents name, code status, primary diagnosis, admission date, personal contacts information and medical professionals contact information) revealed Resident 5 was admitted to the facility on [DATE]. A record review of Resident 5's Care plan (Care Plan – a personalized, actionable document that outlines a patient's health needs, goals, and specific interventions to manage their care) revealed the following diagnoses: Essential Hypertension (high blood pressure with no single, identifiable medical cause), Cardiomyopathy (a disease of the heart muscle, causing it to become enlarged, thick or rigid, making it harder for the heart to pump blood effectively to the rest of the body), Paroxysmal Atrial Fibrillation (a type of irregular, rapid heart rhythm that starts and stops suddenly, with episodes typically lasting less than 7 days, often resolving on their own) and Hypotension (abnormally low blood pressure, generally lower than 90/60 mmHg (mmHg – a standard unit used to measure blood pressure). A record review of Resident 5's Order Summary (a consolidated, authorized record of instructions from a licensed provider detailing a resident's care, treatment, medications, and services) dated 5/11/2026 revealed the following orders: -Daily BP (blood pressure – the force of blood pushing against the artery wall) and HR (heart rate – the number of times a heart beats in a minute); Call if HR>115, SBP (systolic blood pressure – the first number in a blood pressure reading, measuring the maximum pressure in your arteries when your heart beats and pumps blood out) <90 or SBP>180. every shift for BP & (heart (continued on next page)

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	285054	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rate) HR monitor. Date: 09/10/2024 -Midodrine HCl (a prescription medication used to treat a sudden drop in blood pressure upon standing which works by restricting blood vessels to increase blood pressure)Oral Tablet 5 MG (Midodrine HCl) Give 1 tablet via PEG -Tube (Percutaneous Endoscopic Gastrostomy – a soft flexible feeding tube inserted through the abdomen directly into the stomach to deliver nutrition fluids, and medication) three times a day for hypotension (low blood pressure) Hold if SBP> 120 mmHg sitting; take at least 4 hours prior to bedtime. Dated: 12/20/2025 -Metoprolol Tartrate (a prescription medication used to treat high blood pressure by slowing the heart rate and reducing strain on the heart) Oral Tablet 25mg. Give 12.5 milligrams (mg) by mouth two times a day for HTN Hold if SBP <90 or HR <60 Dated: 02/02/2026. A record review of Resident 5's Medication Administration Record (MAR) revealed the following information: Residents 5's morning HR on 4/8/2026 was 58 beats per minute (bpm), on 4/10/2026 it was 58, on 4/17/2026 it was 58, on 4/20/2026 it was 43, and on 4/29/26 it was 56. Resident 5 received Metoprolol Tartrate 12.5mg on each of these days. The medication order the Metoprolol was to be held (not given) for HR of less than 60. Resident 5's morning BP was 72/40 on 4/5/2026. It was 81/29 on 4/12/2026, 78/56 on 4/14/2026 and 88/58 on 4/29/2026. Resident 5 received Metoprolol Tartrate 12.5mg on each of these days. The medication order stated Metoprolol Tartrate should be held for SBP of less than 90. Resident 5's BP was 131/81 on 4/1/2026 at 2:00PM, 128/60 on 4/2/2026 at 2:00PM, 125/85 on 4/9/2026 at 2:00PM, 133/84 on 4/10/2026 at 2:00PM, 125/81 on 4/16/2026 at 2:00PM, and 132/76 on 4/19/2026 at 2:00PM. Resident 5 received Midodrine HCL 5mg on these dates for the mid-afternoon medication pass. The medication order stated Midodrine HCL was to be held if the SBP was greater than 120. An interview on 5/11/2026 at 10:20 AM with RN J confirmed the Metoprolol should not have been given on 4/1/2026, 4/10/2026,4/17/2026, 4/20/2026, and 4/29/2026 due to Resident 5's heartrate was less than 60 on these dates. An interview on 5/11/2026 at 10:20 AM with RN J confirmed the Metoprolol should not have been given on 4/5/2026, 4/9/2026, 4/12/2026, 4/14/2026, and 4/29/2026 because Resident 5's SBP was less than 120 on these dates. An interview on 5/11/2026 at 10:20 Am with RN J confirmed the Midodrine should not have been given for Resident 5's 2:00 PM BP on 4/1/2026, 4/2/2026, 4/9/2026, 4/10/2026, 4/16/2026 and 4/19/2026. RN J confirmed the Midodrine was to be held if the SPB was greater than 120. RN J confirmed each instance was a medication error.